Sample Letter

CCSP Office Letterhead

Telephone Number ( ) _____

Date _____

Applicant Name _____

Address _____

_____

_____

DENIAL OF LEVEL OF CARE
COMMUNITY CARE SERVICES PROGRAM
SECOND REVIEW

State and federal law require that if you receive care in the Community Care Services Program, your medical condition must be such that you require the level of care provided in a nursing facility. This letter is to notify you that after careful review of the additional medical information submitted, our evaluation is that your medical condition does not require the level of care provided in a nursing facility because _____

_____

_____

_____

In accordance with the Code of Federal Regulations, 42 CFR, S 441.301(b)(l)(ii), services to you under the Community Care Services Program are hereby denied.

If you disagree with this denial, you may request a hearing. You have thirty (30) days from the date of this letter to request a hearing. If you make your request orally, you must submit a written request within fifteen (15) days from the date of your oral request.

The hearing will be conducted in your county by an Administrative Law Judge of the Office of State Administrative Hearing. At the hearing, you may represent yourself or have legal counsel, a friend, a relative or any other spokesperson represent you.

You should contact this office immediately at the address listed above to request a hearing. The office will forward your request for a hearing to the Legal Services Office of the Department of Human Resources.

Sincerely,

Care Coordinator _____

Title _____

Telephone Number _____

cc Area Agency on Aging (Name)

Instructions
Community Care Services Program

DENIAL OF LEVEL OF CARE COMMUNITY CARE SERVICES PROGRAM- SECOND REVIEW

Purpose: This form is used to notify an applicant that a level of care has been denied a second time after review of additional medical information.

Who Completes/When Completed: The care coordinator RN completes the notification letter and mails it immediately after reviewing additional information and determining that applicant still doesn't meet a level of care for nursing home care.

Instructions:

1.	Use the letterhead of the care coordination agency.	
2.	Telephone Number:	Enter the telephone number of the care coordination agency.
3.	Date:	Enter date the denial notification is prepared and mailed.
4.	Applicant Name:	Enter the applicant's name.
5.	Address:	Enter the applicant's mailing address.
6.	Denial Reason:	State specifically why the applicant does not meet the level of care on second review.
7.	Sincerely:	Enter signature of the person authorized to act for the agency.
8.	Care Coordinator:	Enter the name of the care coordinator RN.
9.	Title:	Enter the title of the care coordinator RN.
10.	Telephone Number:	Enter the telephone number of the care coordinator RN.

Distribution: Original to the applicant, copy to the AAA, copy filed in applicant's case record.

Sample Letter

CCSP Office
Letterhead

Telephone Number (___)_____

Date _____

Client Name_____

Address _____

_____

_____

TERMINATION OF LEVEL OF CARE
COMMUNITY CARE SERVICES PROGRAM

State and federal law require that if you receive care in the Community Care Services Program, your medical condition must be such that you require the level of care provided in a nursing facility. This letter is to notify you that according to our evaluation, your medical condition no longer requires the level of care provided in a nursing facility because_____
_____
_____
_____
In accordance with the Code of Federal Regulations, 42 CFR, S 441.301(b)(l)(ii), services for you through the Community Care Services Program will be terminated unless additional medical information justifies your remaining in Community Care.

You may obtain a review of this decision by sending additional medical information within ten (10) days of the date of this letter. Contact your attending physician or your original referring agency if you need help obtaining additional medical information to submit with your request for reconsideration. You must submit all information to the Community Care Services Program at the address shown above. You will not lose your right to a hearing if you send additional medical information. If you do not send additional medical information within ten (10) days, this decision will become effective_____ .

If you choose not to send additional medical information but you disagree with this denial, you may request a hearing. You have thirty (30) days from the date of this letter to request a hearing. If you make your request verbal request for a hearing, you must submit a written request within fifteen (15) days from the date of your oral request. If you request a hearing in writing within ten (10) days from the date of this letter, you may continue to receive Community Care Services. An Administrative Law Judge will conduct the hearing in your county. At that hearing, you may represent yourself or use legal counsel, a friend, a relative or any other spokesperson represent you.

You should contact this office immediately at the address above to request a hearing. The office

will forward your request for a hearing to the Legal Services Office of the Georgia Department of Human Resources.

If you choose to continue receiving Community Care Services while waiting for the hearing decision and if the hearing official denies, your appeal, you may be required to repay the Department of Community Health Legal Services Office the cost of any services received after the original termination date.

Sincerely,

Care Coordinator_____

Title_____

Telephone Number _____

cc County DFCS (if MAO)
Area Agency on Aging (Name)

Instructions
Community Care Services Program

TERMINATION OF LEVEL OF CARE
COMMUNITY CARE SERVICES PROGRAM

Purpose: This form letter is used when a client's medical condition no longer meets the level of care provided by a nursing home.

Who Completes/When Completed: The care coordinator completes and mails this form immediately after the care coordinator RN determines that a client no longer meets the level of care criteria for nursing home care.

Instructions:

1. Use the letterhead of the care coordination agency with the information in sample letter.

2. Telephone Number: Enter the telephone number of the coordination agency.

3. Date: Enter the date the termination letter was prepared and mailed.

4. Client Name: Enter the client's name.

5. Address: Enter the client's mailing address.

6. Termination Reason: State specifically why the client no longer meets the level of care.

7. Effective Date: Enter the last day in which a client may submit additional information for a second review of the termination of a level of care. This date is 10 days from the date of the letter.

8. Sincerely: Enter the signature of the person authorized to act for the care coordination agency.

9. Care Coordinator: Enter the name of the care coordinator assigned to the client's case.

10. Title: Enter the title of the care coordinator assigned to the client's case.

11. Telephone Number: Enter the telephone number of the care coordinator assigned to the client's case.

NOTE: Services continue uninterrupted while additional medical information is evaluated by the care coordination team.

Distribution: Original to client, copy to AAA, copy to DFCS (if MAO), copy in client's case record.

Sample Letter

CCSP Office
Letterhead

Telephone Number (_____)_____

Date _____

Client Name_____

Address _____

_____

_____

TERMINATION OF LEVEL OF CARE
COMMUNITY CARE SERVICES PROGRAM
SECOND REVIEW

State and federal law require that if you receive care in the Community Care Services Program, your medical condition must be such that require the level of care provided in a nursing facility. This letter is to notify you that, and after careful review of the additional medical information submitted, our evaluation is that your medical condition no longer requires the level of care provided in a nursing facility because_____
_____
_____
_____

In accordance with the Code of Federal Regulations, 42 CFR, S 441.301(b)(l)(ii), services for you through the Community Care Services Program are hereby terminated effective _____.

If you disagree with this denial, you may request a hearing. You have thirty (30) days from the date of this letter to request a hearing. If you make your request orally, you must submit a written request within fifteen (15) days from the date of your oral request. If you request a hearing in writing within ten (10) days from the date of this letter, you may continue to receive Community Care Services.

An Administrative Law Judge will conduct the hearing in your county. At that hearing, you may represent yourself or have legal counsel, a friend, a relative or any other spokesperson represent you.

You should contact this office immediately at the address above to request a hearing. The office will forward your request for a hearing to the Legal Services Office of the Georgia Department of Human Resources.

If you choose to continue receiving Community Care Services while waiting for the hearing decision and if the hearing official denies your appeal, you may be required to repay the Department of Community Health Legal Services Office, the cost of any services received after the original termination date.

Sincerely,

Care Coordinator_____

Title_____

Telephone Number (___)_____

cc County DFCS (if MAO)
Area Agency on Aging (Name)

Instructions
Community Care Services Program

TERMINATION OF LEVEL OF CARE
COMMUNITY CARE SERVICES PROGRAM-
SECOND REVIEW

Purpose: This form letter is used to notify client that a review of additional information was evaluated and did not change the original determination of termination of level of care.

Who Completes/When Completed: The assigned care coordinator completes and mails the second review termination notice immediately after the care coordination team makes the decision.

Instructions:

1. Use the letterhead of the care coordination agency with the information in this sample letter.

2. Telephone Number: Enter the telephone number of the care coordination agency.

3. Date: Enter the date the second review termination notice was mailed.

4. Client Name: Enter the client's name.

5. Address: Enter the client's mailing address.

6. Termination Reason: State specifically the reason for termination after second review.

7. Effective Date: Enter the effective date of termination. This is 30 days from the date the termination was prepared and mailed.

8. Sincerely: Enter the signature of the person authorized to act for the agency.

9. Care Coordinator: Enter the name of the care coordinator assigned to the client's case.

10. Title: Enter the title of the care coordinator assigned to the client's case.

11. Telephone Number: Enter the telephone number of the care coordinator assigned to the client's case.

Distribution: Original to the client, copy to AAA, copy to DFCS (if MAO), copy in client's case record.

MINIMUM DATA SET - HOME CARE (MDS-HC)

Assessment Detail

Assessment:

Personal Items

Client has advanced medical directives in place
- Yes ☐
- No ☐

Referral Items

Lived in nursing home at anytime in past 5 years
- Yes ☐
- No ☐

Moved to current residence within the past 2 years
- Yes ☐
- No ☐

Cognitive Patterns

Memory
- Memory OK ☐
- Memory Problem ☐

Cognitive Skills for Daily Decision-Making
- Independent ☐
- Modified Independence ☐
- Moderately Impaired ☐
- Severely Impaired ☐

Sudden change in mental function
- No ☐
- Yes ☐

Agitated to extent safety is endangered
- No ☐
- Yes ☐

Communication/Hearing Patterns

Hearing
- Hears Adequately ☐
- Minimal Difficulty ☐
- Hears in Special Situations Only ☐
- Highly Impaired ☐

Making Self Understood
- Understood ☐
- Usually Understood ☐
- Sometimes Understood ☐
- Rarely/Never Understood ☐

Ability to Understand Others
- Understands ☐
- Usually Understands ☐
- Sometimes Understands ☐
- Rarely/Never Understands ☐

Vision Patterns

Vision
- Adequate ☐
- Impaired ☐
- Moderately Impaired ☐
- Highly Impaired ☐
- Severely Impaired ☐

Visual Limitation/Difficulties
- No ☐
- Yes ☐

Vision Decline
- No ☐
- Yes ☐

Indicators of depression/Anxiety

A feeling of sadness or being depressed
- Not exhibited in last 30 days ☐
- Exhibited up to five days a week ☐
- Exhibited daily or almost daily ☐

Persistent anger with self or others
- Not exhibited in last 30 days ☐
- Exhibited up to five days a week ☐
- Exhibited daily or almost daily ☐

Expressions of unrealistic fears
- Not exhibited in last 30 days ☐
- Exhibited up to five days a week ☐
- Exhibited daily or almost daily ☐

Repetitive health complaints
- Not exhibited in last 30 days ☐
- Exhibited up to five days a week ☐
- Exhibited daily or almost daily ☐

Repetitive anxious complaints or concerns
- Not exhibited in last 30 days ☐
- Exhibited up to five days a week ☐
- Exhibited daily or almost daily ☐

Sad, pained, worried facial expressions
- Not exhibited in last 30 days ☐
- Exhibited up to five days a week ☐
- Exhibited daily or almost daily ☐

Recurrent crying, tearfulness
- Not exhibited in last 30 days ☐
- Exhibited up to five days a week ☐
- Exhibited daily or almost daily ☐

Withdrawal from activities of interest
- Not exhibited in last 30 days ☐
- Exhibited up to five days a week ☐
- Exhibited daily or almost daily ☐

Reduced social interaction
- Not exhibited in last 30 days ☐
- Exhibited up to five days a week ☐
- Exhibited daily or almost daily ☐

Assessment Detail

Assessment:

Behavioral Symptoms

Wandering
- Did not occur in last seven days ☐
- Occurred, easily altered ☐
- Occurred, not easily altered ☐

Verbally abusive behavioral symptoms
- Did not occur in last seven days ☐
- Occurred,easily altered ☐
- Occurred, not easily altered ☐

Physically abusive behavioral symptoms
- Did not occur in last seven days ☐
- Occurred, easily altered ☐
- Occurred, not easily altered ☐

Socially inappropriate/disruptive behavior
- Did not occur in last seven days ☐
- Occurred, easily altered ☐
- Occurred, not easily altered ☐

Aggressive resistance of care
- Did not occur in last seven days ☐
- Occurred, easily altered ☐
- Occurred, not easily altered ☐

Changes in behavior symptoms
- No change in behavioral symptoms ☐
- Yes ☐

Involvement

Client is at ease with others
- At ease ☐
- Not at ease ☐

Openly expresses conflict or anger
- No ☐
- Yes ☐

Change in social activities

Decline in participation in social activities
- No decline ☐
- Decline, client not distressed ☐
- Decline, client distressed ☐

Isolation

Length of time client is alone during the day
- Never or hardly ever ☐
- About one hour ☐
- Long periods of time ☐
- All of the time ☐

Client indicates that he/she feels lonely
- No ☐
- Yes ☐

Primary Helper

Lives with client
- Yes ☐
- No ☐
- No such helper (skip other items) ☐

Relationship to client
- Child or child-in-law ☐
- Spouse ☐
- Other relative ☐
- Friend/neighbor ☐

Provides advice or emotional support
- Yes ☐
- No ☐

Provides IADL Care
- Yes ☐
- No ☐

Provides ADL Care
- Yes ☐
- No ☐

Willing to increase emotional support
- More than 2 hours ☐
- 1-2 hours per day ☐
- No ☐

Willing to increase IADL care
- More than 2 hours ☐
- 1-2 hours per day ☐
- No ☐

Willing to increase ADL Care
- More than 2 hours ☐
- 1-2 hours per day ☐
- No ☐

Assessment Detail

Assessment:

Secondary Helper

Lives with client
- Yes ☐
- No ☐
- No such helper (skip other items) ☐

Relationship to client
- Child or child-in-law ☐
- Spouse ☐
- Other relative ☐
- Friend/neighbor ☐

Provides advice or emotional support
- Yes ☐
- No ☐

Provides IADL care
- Yes ☐
- No ☐

Provides ADL Care
- Yes ☐
- No ☐

Willing to increase emotional support
- More than 2 hours ☐
- 1-2 hours per day ☐
- No ☐

Willing to increase IADL care
- More than 2 hours ☐
- 1-2 hours per day ☐
- No ☐

Willing to increase ADL care
- More than 2 hours ☐
- 1-2 hours per day ☐
- No ☐

Caregiver Status

A caregiver is unable to continue in caring activities
- Yes ☐
- No ☐

Primary caregiver is not satisfied with support
- Yes ☐
- No ☐

Primary CG expresses distress/anger/depression
- Yes ☐
- No ☐

Meal Preparation

Self Performance
- Independent - did on own ☐
- Some Help - help some of the time ☐
- Full Help - performed with help all of the time ☐
- By Others - performed by others ☐
- Activity did not occur ☐

Difficulty
- No Difficulty ☐
- Some Difficulty-needs some help,slow/fatigues ☐
- Great Difficulty-little/no involvement is possible ☐

Unmet Need
- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Laundry

Self Performance
- Performs all of the activity ☐
- Performs most of the activity ☐
- Cannot perform most of the activity ☐
- Cannot perform the activity ☐

Unmet Need
- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Ordinary Housework

Self Performance
- Independent - did on own ☐
- Some Help - help some of the time ☐
- Full Help - performed with help all of the time ☐
- By Others - performed by others ☐
- Activity did not occur ☐

Difficulty
- No Difficulty ☐
- Some Difficulty-needs some help,slow/fatigues ☐
- Great Difficulty-little or no involvement possible ☐

Unmet Need
- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Assessment Detail

Assessment:

Managing Finance

Self Performance

- Independent - did on own ☐
- Some Help - help some of the time ☐
- Full Help - performed with help all of the time ☐
- By Others - performed by others ☐
- Activity did not occur ☐

Difficulty

- No Difficulty ☐
- Some Difficulty-needs some help,slow/fatigues ☐
- Great Difficulty-little or no involvement possible ☐

Unmet Need

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Managing Medications

Self Performance

- Independent - did on own ☐
- Some Help - help some of the time ☐
- Full Help - performed with help all of the time ☐
- By Others - performed by others ☐
- Activity did not occur ☐

Difficulty

- No Difficulty ☐
- Some Difficulty-needs some help,slow/fatigues ☐
- Great Difficulty-little or no involvement possible ☐

Phone Use

Self Performance

- Independent - did on own ☐
- Some Help - help some of the time ☐
- Full Help - performed with help all of the time ☐
- By Others - performed by others ☐
- Activity did not occur ☐

Difficulty

- No Difficulty ☐
- Some Difficulty-needs some help,slow/ fatigues ☐
- Great Difficulty-little or no involvement possible ☐

Unmet Need

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Shopping

Self Performance

- Independent - did on own ☐
- Some Help - help some of the time ☐
- Full Help - performed with help all of the time ☐
- By Others - performed by others ☐
- Activity did not occur ☐

Difficulty

- No Difficulty ☐
- Some Difficulty-needs some help,slow/ fatigues ☐
- Great Difficulty-little or no involvement possible ☐

Transportation

Self Performance

- Independent - did on own ☐
- Some Help - help some of the time ☐
- Full Help - performed with help all of the time ☐
- By Others - performed by others ☐
- Activity did not occur ☐

Difficulty

- No Difficulty ☐
- Some Difficulty-needs some help,slow/ fatigues ☐
- Great Difficulty- little or no involvement possible ☐

Unmet Need

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Mobility in Bed

Self Performance

- Independent ☐
- Supervision ☐
- Limited Assistance ☐
- Extensive Assistance ☐
- Total Dependence ☐
- Activity did not occur ☐

Transfer

Self Performance

- Independent ☐
- Supervision ☐
- Limited Assistance ☐
- Extensive Assistance ☐
- Total Dependence ☐
- Activity did not occur ☐

Unmet Need for Care

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Locomotion in Home

Self Performance

- Independent ☐
- Supervision ☐
- Limited Assistance ☐
- Extensive Assistance ☐
- Total Dependence ☐
- Activity did not occur ☐

Assessment Detail

Assessment:

Dressing

Self Performance

- Independent ☐
- Supervision ☐
- Limited Assistance ☐
- Extensive Assistance ☐
- Total Dependence ☐
- Activity did not occur ☐

Unmet Need for Care

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Eating

Self Performance

- Independent ☐
- Supervision ☐
- Limited Assistance ☐
- Extensive Assistance ☐
- Total Dependence ☐
- Activity did not occur ☐

Unmet Need for Care

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Toilet Use

Self Performance

- Independent ☐
- Supervision ☐
- Limited Assistance ☐
- Extensive Assistance ☐
- Total Dependence ☐
- Activity did not occur ☐

Unmet Need for Care

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Personal Hygiene

Self Performance

- Independent ☐
- Supervision ☐
- Limited Assistance ☐
- Extensive Assistance ☐
- Total Dependence ☐
- Activity did not occur ☐

Unmet Need for Care

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Bathing

Self Performance

- Independent - did on own ☐
- Supervision - oversight help only ☐
- Received Assistance in Transfer Only ☐
- Received Assistance in Part of Bathing Only ☐
- Total Dependence ☐
- Activity Did Not Occur ☐

Unmet Need for Care

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Routine Health

Self Performance

- Performs all of the acitvity ☐
- Performs most of the activity ☐
- Cannot perform most of the activity ☐
- Cannot perform the activity ☐

Unmet Need

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Special Health

Self Performance

- Performs all of the activity ☐
- Performs most of the activity ☐
- Cannot perform most of the activity ☐
- Cannot perform the activity ☐

Unmet Need

- Need Is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Being Alone

Self Performance

- Performs all of the activity ☐
- Performs most of the activity ☐
- Cannot perform most of the activity ☐
- Cannot perform the activity ☐

Unmet Need

- Need is met ☐
- Need is met most of the time ☐
- Need is not met most of the time ☐
- Need is seldom or never met ☐

Assessment Detail

Assessment:

Primary Modes of Locomotion

Indoors

- No assistive device ☐
- Cane ☐
- Walker/crutch ☐
- Scooter (e.g. Amigo) ☐
- Wheelchair ☐
- Activity did not occur ☐

Outdoors

- No assistive device ☐
- Cane ☐
- Walker/crutch ☐
- Scooter (e.g. Amigo) ☐
- Wheelchair ☐
- Activity did not occur ☐

Stair Climbing

How well Client went up and down stairs

- Up and down stairs without help ☐
- Up and down stairs with help ☐
- Not go up and down stairs-could without help ☐
- Not go up and down stairs-could do with help ☐
- Not go up and down stairs-no capacity ☐
- Unknown-assessor unable to judge capacity ☐

Stamina

Days client went out of house

- Every day ☐
- 2-6 days a week ☐
- 1 day a week ☐
- No days ☐

Hours of Physical Activities (last 7 days)

- Two or more hours ☐
- Less than two hours ☐

Functional Potential

Client believes he/she capable of more

- Yes ☐
- No ☐

Caregiver believes client capable of more

- Yes ☐
- No ☐

Improved health status expected

- Yes ☐
- No ☐

Bladder Continence

Control of urinary bladder function

- Continent ☐
- Usually Continent ☐
- Occasionally Incontinent ☐
- Frequently Incontinent ☐
- Incontinent ☐

Bladder Devices

Use of pads or briefs to protect against wetness

- Yes ☐
- No ☐

Use of an indwelling catheter

- Yes ☐
- No ☐

Bowel Incontinence

Control of bowel movement

- Continent ☐
- Usually Continent ☐
- Occasionally Incontinent ☐
- Frequently Incontinent ☐
- Incontinent ☐

Assessment Detail

Assessment:

Disease Diagnosis

Cerebrovascular accident (stroke)
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Congestive Heart Failure
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Coronary heart failure
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Hypertension
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Irregularity irregular pulse
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Peripheral vascular disease
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Alzheimer's
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Dementia other than Alzheimer's disease
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Head trauma
- Not Present ☐
- Present-not treated/monitored by nurse ☐
- Present-monitored/treated by nurse ☐

Multiple sclerosis
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Parkinsonism
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Arthritis
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-treated/monitored by nurse ☐

Hip Fracture
- Not Present ☐
- Present- not monitored/treated by nurse ☐
- Present-treated/monitored by nurse ☐

Other fractures (e.g., wrist, vertebral)
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Osteoporosis
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Cataract
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Glaucoma
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Any psychiatric diagnosis
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

HIV infection
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Pneumonia
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Tuberculosis
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Urinary tract infection (in last 30 days)
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Cancer (in past 5 yrs) not including skin cancer
- Not Present ☐
- Present- not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Diabetes
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Emphysema/COP/Asthma
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Renal failure
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Thyroid disease (hyper or hypo)
- Not Present ☐
- Present-not monitored/treated by nurse ☐
- Present-monitored/treated by nurse ☐

Assessment Detail

Assessment:

Other Current/Detailed Diagnosis

Other disease #1

- Record under comments ☐

Other disease #2

- Record under comments ☐

Other disease #3

- Record under comments ☐

Other disease #4

- Record under comments ☐

Preventative Health

Blood Pressure Measured in past 2 years

- Yes ☐
- No ☐

Received Influenza vaccination in past 2 years

- Yes ☐
- No ☐

If female, had breast exam or mammography

- Yes ☐
- No ☐

Problem/Conditions - 2 of last 7 days

Diarrhea

- Yes ☐
- No ☐

Difficulty urinating,urinating 3+ times/night

- Yes ☐
- No ☐

Fever

- Yes ☐
- No ☐

Loss of appetite

- Yes ☐
- No ☐

Vomiting

- Yes ☐
- No ☐

Problem/Conditions in Last Week

Change in sputum production

- Yes ☐
- No ☐

Chest pain at exertion or pain/pressure at rest

- Yes ☐
- No ☐

Constipation in 4 of last 7 days

- Yes ☐
- No ☐

Dizziness or lightheadedness

- Yes ☐
- No ☐

Edema

- Yes ☐
- No ☐

Shortness of breath

- Yes ☐
- No ☐

Delusions

- Yes ☐
- No ☐

Hallucinations

- Yes ☐
- No ☐

Pain

Frequently complains or show evidence of pain

- No Pain ☐
- Pain less than daily ☐
- Pain daily ☐

Pain is unusually intense

- Yes ☐
- No ☐

Pain intensity disrupts usual activities

- Yes ☐
- No ☐

Character of pain

- No Pain ☐
- Localized-single site ☐
- Multiple sites ☐

Pain controlled by medication

- No Pain ☐
- Medication offered no control ☐
- Pain is partially/fully controlled by medication ☐

Falls Frequently

Number of times fell in last 180 days

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐
- 8 ☐
- 9 or more ☐

Assessment Detail

Assessment:

Danger of fall

Unsteady gait

- Yes ☐
- No ☐

Limits going outside due to fear of falling

- Yes ☐
- No ☐

Life Style (Drinking and Smoking)

Felt the need/was told to cut down on drinking

- Yes ☐
- No ☐

Had to have a drink first thing in morning

- Yes ☐
- no ☐

Number of days client had one or more drinks

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Number of drinks consumed per day

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐
- 8 ☐
- 9 or more ☐

Smoked or chewed tobacco daily

- Yes ☐
- No ☐

Health status indicators

Client feels he/she has poor health (when asked)

- Yes ☐
- No ☐

Has conditions/problems that make them unstable

- Yes ☐
- No ☐

Has had a flare-up or recurrent or chronic problem

- Yes ☐
- No ☐

Treatments changed due to new acute episode

- Yes ☐
- No ☐

Prognosis of less than 6 months to live

- Yes ☐
- No ☐

Other status indicators

Fearful of family member or caregiver

- Yes ☐
- No ☐

Unusually poor hygiene

- Yes ☐
- No ☐

Unexplained injuries,broken bones,or burns

- Yes ☐
- No ☐

Neglected, abused or mistreated

- Yes ☐
- No ☐

Physically restrained

- Yes ☐
- No ☐

Weight Change

Unintended weight loss

- Yes ☐
- No ☐

Consumption

4 of last 7 days, ate 1 or less meals a day

- Yes ☐
- No ☐

Decrease in amt of food/liquids client consumes

- Yes ☐
- No ☐

Insufficient fluid

- Yes ☐
- No ☐

Assessment Detail

Assessment:

Nutritional treatments

days IV/Infusion therapy - hydration

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Fluids by mouth

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Parenteral nutrition (TPN or lipids)

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Enteral -tube feeding

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Oral Status

Problem chewing or swallowing

- Yes ☐
- No ☐

Mouth is dry when eating a meal

- Yes ☐
- No ☐

Problem brushing teeth or dentures

- Yes ☐
- No ☐

Skin Condition

Troubling skin conditions or changes

- Yes ☐
- No ☐

Pressure Ulcer

- No Ulcer ☐
- Stage 1 ☐
- Stage 2 ☐
- Stage 3 ☐
- Stage 4 ☐

Stasis Ulcer

- No Ulcer ☐
- Stage 1 ☐
- Stage 2 ☐
- Stage 3 ☐
- Stage 4 ☐

Burns

- Yes ☐
- No ☐

Open lesions other than ulcers,rashes,cuts

- Yes ☐
- No ☐

Skin tears or cuts

- Yes ☐
- No ☐

Surgical wound site - thorax

- Yes ☐
- No ☐

Surgical wound site - abdomen

- Yes ☐
- No ☐

Surgical wound site - extremities

- Yes ☐
- No ☐

Surgical wound site - other

- Yes ☐
- No ☐

History of resolved pressure ulcer

- Yes ☐
- No ☐

Assessment Detail

Assessment:

Wound/Ulcer Care

Days rec'd Antibiotics, systemic or topical

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Days rec'd Dressing

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Days rec'd Pressure reduction.relieving devices

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Days rec'd Nutrition or hydration

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Days rec'd Turning/repositioning

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Days rec'd Debridement

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Days rec'd Surgical wound care

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐

Foot problems

Corns,calluses,structural problems,infections,fungi

- Yes ☐
- No ☐

Open lesions on the foot

- Yes ☐
- No ☐

Foot not inspected in 90 days by client or others

- Yes ☐
- No ☐

Home Environment

Lighting in evening

- Yes ☐
- No ☐

Flooring and carpeting

- Yes ☐
- No ☐

Bathroom and toiletroom

- Yes ☐
- No ☐

Kitchen

- Yes ☐
- No ☐

Heating and cooling

- Yes ☐
- No ☐

Personal safety

- Yes ☐
- No ☐

Access to home

- Yes ☐
- No ☐

Access to rooms in house

- Yes ☐
- No ☐

Living Arrangement

Client now lives with other persons

- Yes ☐
- No ☐

Believes client would be better in new environment

- No ☐
- Client only ☐
- Caregiver only ☐
- Client and caregiver ☐

Assessment Detail

Assessment:

Treatments

Alcohol/drug treatment program
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Blood transfusions
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Chemotherapy
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Cardiac rehabilitation
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Continuous positive airway pressure (CPAP)
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Dialysis-peritoneal (CAPD)
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Dialysis-renal
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Holter monitor
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

IV infusion - central
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

IV infusion - peripheral
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Medication by injection
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Ostomy care
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Oxygen therapy - intermittent
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Oxygen therapy- continuous (concentrator)
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Oxygen therapy -continuous (other)
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Radiation therapy
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Respiratory therapy
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Tracheostomy care
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Ventilator
- Not applicable ☐
- Scheduled, full adherence as prescribed ☐
- Scheduled, partial adherence ☐
- Scheduled, not received ☐

Assessment Detail

Assessment:

Therapies

Exercise therapy
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Occupational therapy
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Physical therapy
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Respiratory therapy (including suctioning, IPPB)
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Programs

Day center
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Day hospital
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Hospice care
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Physician or clinic visit
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Respite care
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Special procedures done in home

Daily nurse monitoring (e.g.,EKG,urinary output)
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Nurse monitoring less than daily
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Medical alert bracelet or electronic security alert
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Skin treatment
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Special diet
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Other
- ☐ Not applicable
- ☐ Scheduled, full adherence as prescribed
- ☐ Scheduled, partial adherence
- ☐ Scheduled, not received

Management of equipment

Oxygen
- ☐ Not used
- ☐ Managed on own
- ☐ Managed on own if laid out/ with reminders
- ☐ Partially performed by others
- ☐ Fully performed by others

IV
- ☐ Not used
- ☐ Managed on own
- ☐ Managed on own if laid out/with reminders
- ☐ Partially performed by others
- ☐ Fully performed by others

Catheter
- ☐ Not used
- ☐ Managed on own
- ☐ Managed on own if laid out/with reminders
- ☐ Partially performed by others
- ☐ Fully performed by others

Assessment Detail

Assessment:

Visits

Number of times admitted to hospital

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐
- 8 ☐
- 9 or more ☐

Number of emergency room visits

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐
- 8 ☐
- 9 or more ☐

Emergency care

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐
- 8 ☐
- 9 or more ☐

Treatment goals

Any treatment goals that have been met

- Yes ☐
- No ☐

Change in care needs

Self sufficiency has change significantly

- No change ☐
- Improved - receives fewer supports ☐
- Deteriorated - receives more support ☐

Trade offs

Client made financial trade-offs

- Yes ☐
- No ☐

Number of medications

Record the number of different medications

- 0 ☐
- 1 ☐
- 2 ☐
- 3 ☐
- 4 ☐
- 5 ☐
- 6 ☐
- 7 ☐
- 8 ☐
- 9 ☐

Psychotropic medication

Antipsychotic

- Yes ☐
- No ☐

Antianxiety

- Yes ☐
- No ☐

Antidepressant

- Yes ☐
- No ☐

Hypnotic

- Yes ☐
- No ☐

Medical oversight

Physician reviewed medications as a whole

- Discussed with one MD (or no medications taken) ☐
- No single MD reviewed all medications ☐

Compliance with medications

Compliant all or most of the time with medications

- Always compliant ☐
- Compliant 80% of time and more ☐
- Compliant less than 80% of time ☐
- No medications prescribed ☐

Instructions
Community Care Services Program

MINIMUM DATA SET- HOME CARE (MDS-HC)

Purpose: This form is used to assess a client's needs, strengths and preferences for home care.

Who Completes/When Completed: Care coordinators complete the MDS-HC at initial assessment and reassessment.

Instructions:

Use MDS-HC to complete assessments and reassessments in CHAT.
Print the short version of MDS-HC with client's responses for client files and providers.
If the long version is used for the interview with the client, key the responses before printing the short version.

NOTE: Care coordinators use the instructions in RAI-Home Care Assessment Manual to become familiar with completing the MDS-HC.